



**Advocates
For Youth**

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Serving Youth of Color

Transitions

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Youth of Color—At Disproportionate Risk of Negative Sexual Health Outcomes

In the United States, rates of HIV and other sexually transmitted infections (STIs) as well as of unintended pregnancy are disproportionately high among youth of color, especially among black and Hispanic youth. Social, economic, and cultural barriers limit the ability of many youth of color to receive accurate and adequate information on preventing HIV, STIs, and unwanted pregnancy. Youth of color need 1) comprehensive, accurate information and 2) culturally competent, confidential, and affordable services.

Youth of Color Suffer Relatively High Rates of HIV and STIs.

- Through 2001, African Americans and Latinas accounted for 84 percent of cumulative AIDS cases among women ages 13 to 19 and 78 percent of cases among women ages 20 to 24. Through 2001, African Americans and Latinos accounted for 62 percent of cumulative AIDS cases among men ages 13 to 19 and 60 percent of cases among men ages 20 to 24.¹
- In 2001, the chlamydia rate among women ages 15 to 19 was nearly seven times higher among African Americans than among whites (8,483 and 1,276 per 100,000, respectively). Among males ages 15 to 19, chlamydia rates were 12 times higher among African Americans than among whites (1,550 and 128 per 100,000, respectively).²
- In the same year, 75 percent of all reported cases of gonorrhea occurred among African Americans for whom the gonorrhea rate was 782 per 100,000 population, compared to 114 among Native Americans, 74 among Latinos, and 29 among non-Hispanic whites.²

Birth Rates Fell among Teens in All Ethnic/Racial Groups, But Remained Higher than the Overall Rate among Some Groups.

- Preliminary data for 2002 indicate an historically low birth rate—42.9 births per 1,000 women, ages 15 to 19.³
- Between 1991 and 2001, U.S. birth rates among 15- to 19-year-old women declined in all ethnic/racial groups, although rates for black and Hispanic teens remain higher than rates for other groups.^{3,4}
- Hispanic teens have higher birth rates than any other group—86.4 per 1,000 women ages 15 to 19 compared to 71.8 among black teens; 56.3 among Native Americans; 30.3 among white, non-Hispanics; and 19.8 among Asian and Pacific Islander (A&PI) teens.³
- Black women ages 15 to 19 experienced the steepest decline (37 percent) in birth rates, down from 116 per 1,000 women in 1991. At the same time, birth rates among Native American teens declined 23 percent; those among A&PI teens declined 22 percent; and among Hispanic teens, 13 percent.⁴

Sexual Risk Behaviors among Youth of Color Put Them at Risk.

- Among high school students in 2001, 61 percent of black, 48 percent of Hispanic, and 43 percent of white youth reported ever having had sexual intercourse.⁵
- At the same time, 27 percent of black youth and 15 percent of Hispanic youth reported four or more lifetime sexual partners, as did 12 percent of white youth.⁵
- Among sexually experienced high school students in 2001, black youth were significantly more likely than their white or Hispanic peers to report condom use at most recent sex (67, 57, and 54 percent respectively).⁵

Youth of Color Face Significant Barriers to HIV/STI and Pregnancy Prevention Services.

- Latina women face cultural barriers to consistent condom use, such as machismo and Catholicism's opposition to birth control. For example, Puerto Rican women's greatest obstacle to negotiating safer sex, including condom use, is the cultural expectation to respect males and to be submissive.⁶

- In a study of African American women ages 13 to 19, 26 percent felt little control over whether or not a condom was used during intercourse; 75 percent agreed that, if a male knew a female was taking oral contraceptives, he would not want to use a condom; 66 percent felt that a male partner would be hurt, insulted, or suspicious if asked about his HIV risk factors.⁷
- For many women, negotiating condom use also seems to question trust and fidelity. In one study, African American teenage women felt that not using a condom with a steady partner was a symbol of trust in their partner and the relationship.⁷ Moreover, considering asking a partner to wear a condom sometimes brought up fear of rejection or violence.^{7,8}
- Persistent inequality and painful memories of medical abuses and the consequent mistrust of the U.S. government contribute to conspiracy theories, such as HIV as an agent of genocide, that hamper HIV education efforts in some ethnic communities.⁹
- One study found that many African Americans and Latinos held misperceptions about HIV transmission, trusted the accuracy of partners' reported histories, and, particularly among women, misunderstood the meaning of *safer sex*.¹⁰
- Urban minority adolescents reported high levels of worry about AIDS, but they reported equal or greater concerns about having enough money to live on, general health, doing well in school, getting pregnant, and getting hurt in a street fight.⁷ For these women, HIV risk reduction could be secondary to basic needs, such as housing, food, transportation, and child care.⁸
- Youth of color experience higher rates of medical indigence than do white youth, and they more often confront financial, cultural, and institutional barriers in obtaining health care.¹¹ For many youth of color, publicly funded health insurance provides limited access to comprehensive, adolescent-appropriate health services.¹¹

Programs Can Be Effective in Serving Youth of Color.

No single strategy will work for all youth, even within a single community. Programs are most likely to be effective when they—

- Incorporate comprehensive sexuality education, including information on *both* contraception and abstinence.^{12,13}
- Provide access to contraceptive services and methods.^{14,15, 16,17,18}
- Offer opportunities—such as community service—that develop life skills so young people can prepare for their futures.¹⁹

HIV/STI and teen pregnancy prevention programs targeting youth of color are also most likely to be effective when they—

- Are culturally competent and in the language of the target population^{19,20}
- Involve community members and youth in planning and implementation²¹
- Focus on the assets of teenage participants and on the needs of the whole young person²²
- Consider the social and cultural factors that influence behavior¹⁶
- Provide peer support to change peer norms²³
- Offer gender-specific opportunities and activities²⁴
- Aim at building skills^{25,26}
- Use multiple pathways to reach and empower youth in the community.²⁴

Reference:

- Centers for Disease Control & Prevention (CDC). *HIV/AIDS Surveillance Report* 2002; 13(2):1-44.
- CDC. *Sexually Transmitted Disease Surveillance, 2001*. Atlanta, GA: Author, 2002.
- Hamilton BE et al. Births: preliminary data for 2002. *National Vital Statistics Reports* 2003; 51(11):1-20.
- Ventura SL et al. Births to teenagers in the United States, 1940-2000. *National Vital Statistics Reports* 2001; 49(10):1-19.
- Grunbaum JTMA et al. Youth risk behavior surveillance, United States 2001. *Morbidity & Mortality Weekly Report (MMWR), Surveillance Summaries* 2002; 51(SS-4):1-64.
- Weeks MR et al. AIDS prevention for African American and Latina women: building culturally and gender-appropriate interventions. *AIDS Education & Prevention* 1995;7:251-263.
- Overby KJ, Kegeles SM. The impact of AIDS on an urban population of high-risk female minority adolescents. *Journal of Adolescent Health* 1994;15:216-227.
- AIDS Action. *What Works in Prevention for Women of Color*. Washington, DC: Author, 2001.
- Pittman KJ et al. Making sexuality education and prevention programs relevant for African American youth. *Journal of School Health* 1992;62:339-344.
- Essien EJ et al. Misperceptions about HIV transmission among heterosexual African American and Latino men and women. *Journal of the National Medical Association* 2002;94:302-312.
- Office of Women's Health. *Women of Color Health Data Book: Adolescents to Seniors*. Bethesda, MD: National Institutes of Health, 1998.
- Baldo M et al. *Does Sex Education Lead to Earlier or Increased Sexual Activity in Youth?* Presentation, IXth International Conference on AIDS, Berlin, 6-10 June 1993. Geneva: World Health Organization, 1993.
- Grunseit A et al. Sexuality education and young people's sexual behavior: a review of studies. *Journal of Adolescent Research* 1997;12:421-453.
- Singh S et al. Adolescent pregnancy and childbearing: levels and trends in developed countries. *Family Planning Perspectives* 2000; 32:14-23.
- CDC. State-specific pregnancy rates among adolescents, United States, 1992-1995. *Morbidity & Mortality Weekly Report* 1998;47:497-501+.
- Koo HP et al. Reducing adolescent pregnancy through a school- and community-based intervention: Denmark, South Carolina revisited. *Family Planning Perspectives* 1994;26:206-211+.
- Zabin LS et al. Evaluation of a pregnancy prevention program for urban teenagers. *Family Planning Perspectives* 1986;18:119-122+.
- Frost JJ et al. Understanding the impact of effective teenage pregnancy prevention programs. *Family Planning Perspectives* 1995;27:188-195.
- Allen JP, Philliber S. Who benefits most from a broadly targeted prevention program? Differential efficacy across populations in the Teen Outreach Program. *Journal of Community Psychology* 2001;29:637-655.
- Kalichman SC et al. Culturally tailored HIV/AIDS risk reduction messages targeted to African American urban women. *Journal of Consulting & Clinical Psychology* 1993;61:291-295.
- Epstein J. *Family Planning and Adolescent Health: Facing the Challenge*. Seattle, WA: Center for Health Training, 1994.
- Blyth DA. *Healthy Communities, Healthy Youth: How Communities Contribute to Positive Youth Development*. Minneapolis, MN: Search Institute, 1993.
- Mason H. *Peer Education: Promoting Healthy Behaviors*. [The Facts] Washington, DC: Advocates for Youth, 2003.
- Kirby D. *No Easy Answers*. Washington, DC: National Campaign to Prevent Teen Pregnancy, 1997.
- Niego S et al. *The PASHA Field Test: A Window on the World of Practitioners*. Los Altos, CA: Sociometrics, 1998.
- Jemmott JB et al. Reductions in HIV risk-associated sexual behavior among black male adolescents: effects of an AIDS prevention program. *American Journal of Public Health* 1992;82:372-377.



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YOUTH OF COLOR—RIGHTS. RESPECT. RESPONSIBILITY.®

A STRATEGY TO PROMOTE SEXUAL HEALTH

Youth of color* in the United States are at disproportionate risk of negative sexual health outcomes, including HIV, other sexually transmitted infections (STIs), and unintended pregnancy. These youth are at risk, in part, because of society's neglect, indifference, or outright hostility—factors that greatly compound the developmental issues all adolescents face.

Advocates for Youth is committed to shifting society's paradigm regarding youth, including youth of color, away from one that views them as “problems to be solved,” and towards one that values them and that eagerly seeks their full participation in designing and running programs for young people. Advocates for Youth calls this paradigm shift the 3Rs—*Rights. Respect. Responsibility.*®

- Adolescents have **rights** to balanced, accurate, and realistic sexuality education, confidential and affordable sexual health services, and a secure stake in the future.
- Youth deserve **respect**. Today, they are perceived only as part of the problem. Valuing young people means they are part of the solution and are included in the development of programs and policies that affect their well-being.
- Society has the **responsibility** to provide young people with the tools they need to safeguard their sexual health, and young people have the responsibility to protect themselves from too early childbearing and sexually transmitted infections, including HIV.

A values-based approach to serving youth asserts that every young person is of infinite value, regardless of race/ethnicity, gender, health status, socio-economic background, sexual orientation, and/or gender identity. Valuing youth provides an ethical imperative to acknowledge and serve youth of color positively and with respect, to promote their well-being, and to encourage their success.

Rights, respect, responsibility® applies to *all* youth. Nevertheless, because racism, disproportionate poverty, and barriers to opportunity in U.S. society may hamper the success and limit the aspirations of youth of color, it is especially critical that educators, youth-serving professionals, parents, communities of faith, and health care providers work to promote the 3Rs among and for youth of color. Many programs and approaches exist that specifically serve youth of color, helping them to value themselves and their communities, to combat racism, and to avoid or reduce sexual health risks. Some successful programs serve youth of a particular race/ethnicity; others offer services to youth from a variety of ethnic backgrounds. Their insights and successes can help other programs that do not focus solely—or at all—on youth of color to begin serving *all* youth sensitively and appropriately. Programs that respect young people's right to make responsible decisions about sex will also work to develop policies and environments that support *all* youth in this goal, irrespective of young people's race/ethnicity, language, gender, or sexual orientation.

This issue of *Transitions* compiles information about issues faced by youth of color, including HIV-positive youth and gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth of color. It considers how concepts of masculinity contribute to young men's sexual risk behaviors and their problems in intimate relationships. It discusses the interplay of cultural competence and social justice and how to create culturally relevant programs. It discusses barriers to health care and arts programs that promote young people's sexual health. Stories by youth of color underscore the importance of the 3Rs paradigm, and a lesson plan provides opportunities for young people to improve communication skills related to sexual risk reduction. Finally, this issue provides links to national and online resources.

There are many taboos surrounding sexuality in my [South Asian] culture. Speaking of sexuality is not allowed. When a loved one is lost to HIV/AIDS, not being able to speak about it brings additional grief. And it hurts, especially, to know such a death could have been prevented with education. This has been my inspiration for becoming a youth activist. Young people are the future, and people under age 22 are the first generation to spend their entire lives worrying about or confronted with HIV/AIDS. Why would we want to risk our lives through ignorance?

Ritu, member, Young Women of Color Leadership Council, Advocates for Youth

* Throughout this issue, youth of color includes African Americans/blacks, Asian and Pacific Islanders (A&PI), Latinos/Hispanic youth, and Native Americans or American Indian/Alaska natives.

CULTURAL COMPETENCE & SOCIAL JUSTICE: A PARTNERSHIP FOR CHANGE

By Jonathan Stacks, MSW, Project Coordinator, Youth Empowerment Initiatives;
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Cultural competence is essential in addressing the sexual and reproductive health needs of young people of color, including gay, lesbian, bisexual and transgender (GLBT) youth of color. Indeed, cultural competence is vital to every program's effectiveness, not just to those serving "minority" groups. Culturally relevant programs and culturally competent individuals can better serve youth, and when cultural competence partners with social justice, society may finally achieve equality in health outcomes for all young people, regardless of their race/ethnicity, language, gender, religion, or sexual orientation.

What Is Culture?

Here, we define culture as a "system of interrelated values [that] influence and condition perception, judgment, communication, and behavior."¹ Everyone looks at the world through a lens, as though through a pair of glasses. While this lens is unique to each individual, the worldviews of people of similar background or social experience is often similar. This similar worldview creates a shared understanding of society. One's involvement in these social groups can be referred to as his/her cultural identity. To understand a culture is to understand a particular worldview.

What Is Cultural Competence?

Cultural competence moves beyond "cultural awareness" (knowledge of another cultural group) and "cultural sensitivity" (knowledge as well as experience with another culture).² Cultural competence acknowledges and responds to the unique worldviews of different people and communities. The way an individual views the world comes from her/his life experiences, many of which are shared by others within the same culture. To understand the individual, one must understand these experiences. Besides recognizing cultural patterns of behavior, the culturally competent person must also acknowledge the social inequities faced by others.

Cultural competence matters because the public health community acknowledges that using one method to reach every person and every community is far less effective—and sometimes completely ineffective—than creating and/or adapting programs to meet the specific cultural context of a particular population. For public health endeavors, cultural competence is the level of knowledge-based skills necessary for providing effective services to individuals from a particular group—however the group is defined.³

What Is Social Inequality?

Champions of *social justice* assert that the foundation of a free society lies in 1) equally valuing all citizens by granting them equal political and civil liberties; 2) meeting their basic needs of income, shelter, and other necessities; and 3) offering each one opportunities and life chances.⁴ Unfortunately, societies usually offer citizens unequal access to education, career opportunities, money, and power. Some individuals—due to cultural identity, gender, skin color, national origin, or sexual orientation, among other attributes—have greater and easier access to a society's resources than do others. In discussing inequitable power and resource distribution, social scientists usually use *privilege* to indicate preferred access to power and resources. They use *oppression* to indicate barriers to power and resources.

Every person has more than a single cultural identity and, thus, in different situations, varied experiences of privilege or oppression. For example, while a heterosexual African American young man may be unable to shop in some stores without being harassed by security, he can usually publicly, and without fear, display his affection for his female partner. At the same time, a white, gay male may be able to shop without being followed around by security but can seldom publicly and fearlessly display his affection for his male partner. True cultural competence demands an understanding of social inequalities and how they affect individuals and communities.

Social Inequality Affects Health.

Social inequality has a profound affect on health and public health outcomes. Yet, it has too often been left out of public health discussions. Research demonstrates a direct correlation between inequality and negative health outcomes. For example, "in the United States between 1980 and 1990, states with the highest income inequality showed a slower rate of improvement in average life expectancy than did states with more equitable income distributions."⁵

Another example is the HIV/AIDS epidemic in the United States. Groups disproportionately affected by the epidemic are also historically oppressed groups—communities of color, women, men who have sex with men, the poor, and young people. All these groups experience serious limitations in their access to resources, especially education, adequate and responsive health care, power to set policy, and opportunities to create relevant media messages. Inequality creates and perpetuates feelings of powerlessness. The link between inequality and health outcomes is a starkly clear reason for linking cultural competence and social justice.

So, how do we achieve socially just cultural competence? By taking three steps: 1) self-awareness, 2) self-analysis, and 3) community partnership.

Self-awareness

Cultural competence means gaining knowledge about both our own culture(s) and the culture(s) with which we work. This process must begin with each of us, before moving outward to the community. Self-awareness means thoroughly examining our own lifestyle, thoughts, and assumptions—particularly our cultural assumptions. For example, our inner feelings about affirmative action, immigration laws, gay marriage, inter-ethnic adoptions and/or intimate relationships, and hate crimes are often part and parcel of our cultural attitudes and biases. Self-awareness requires both thought and discussion with our friends, co-workers, family, and strangers about these beliefs and the situations those beliefs affect. Do we assume that, based on race/ethnicity, we are more likely to be smart, energetic, or responsible than others? Do we assume that someone else will be better at interior design or sports, based on his/her sexual orientation or race/ethnicity? Becoming aware of these automatic assumptions is the first step towards socially just cultural competence.

We also need to examine our position in society and our experience of privilege and oppression. How has our own experience of privilege and/or oppression shaped our worldview? Do we feel entitled to have our opinions heard by policy makers or do we feel that policy makers will not listen to us? Do we think some particular racial/ethnic group is lazier, smarter, or more avaricious or philanthropic than our own? Bah, humbug! When we find exceptions to our internal worldview, we must recognize that these exceptions disprove our cultural biases.

Self-analysis

How do our attitudes, values, and beliefs shape our interactions with others? We need to *assess* the impact of our cultural upbringing upon our concepts of other cultural and ethnic groups and upon our actions in the world. What attitudes did we adopt unthinkingly at an early age? How do our actions reflect those attitudes and what real world experience shows these attitudes to be unfair and/or hurtful to others? True cultural competency requires understanding our own biases and how those biases affect our actions before we even attempt to understand the beliefs, traditions, and values of others.

Community partnership

The third step toward socially just cultural competence is to enter community partnerships. The process of becoming culturally competent now moves outward from the individual, into the community. And what better place to engage in an outward dialogue than with the communities we serve?

Too often, organizations stand between funding sources and the community, serving the community, yet not sharing monetary decisions with it. By limiting communities' direct access to funding, the organization perpetuates social inequality. By creating a true partnership with the community, an organization establishes equality and encourages the community to make *its own* decisions about public health issues, goals, and spending. Through working hard, building mutual trust, and ensuring mutual commitment to shared goals and to genuine equality, communities and youth-serving organizations can build effective partnerships in which the community's expertise (knowledge and shared experiences) and resources (people) join with the expertise (research on best practices) and resources (access to funding) of the organization. The results of empowering communities through genuine partnership may be improved sexual health outcomes among young people of color.

It's Time for Socially Just Culturally Competence.

Despite public discussions and civil rights struggles over the past decades, youth of color grow up with firsthand understanding and experience of inequality and injustice. Discrimination and little hope for the future sometimes leave youth of color with little incentive to protect themselves. In many communities of color, sexual health outcomes reflect the inequities faced by young people. Public health organizations and those working with youth of color need to establish socially just and culturally relevant programs and to hire and train culturally competent staff. Then, organizations and programs will be able to serve youth of color as they deserve and to encourage these youth to achieve positive sexual health outcomes.

References

- ¹ Airhihenbuwa CO. *Health & Culture: Beyond the Western Paradigm*. Thousand Oaks, Sage, 1995.
- ² Messina SA. *A Youth Leader's Guide to Building Cultural Competence*. Washington, DC: Advocates for Youth, 1993.
- ³ Kaiser Family Foundation. *Compendium of Cultural Competence Initiatives in Health Care*. Menlo Park, CA: The Foundation, 2003.
- ⁴ Bowring B. Forbidden relations? The UK's discourse of human rights and the struggle for social justice. *Law, Social Justice & Global Development Journal* 2002; 1.
- ⁵ Daniels N, Kennedy B, Kawachi I. Justice is good for our health. *The Boston Review* 2000; 25.

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CREATING CULTURALLY COMPETENT PROGRAMS

By Jennifer Augustine, MPH, CHES, Program Manager, HIV/STI Prevention Programs, Advocates for Youth

Cultural competence is an issue, not only for mainstream America, but also for all who want to reach people who don't look, think, or speak like them. Demographic changes in the United States and efforts to eliminate health disparities among people of diverse ethnic and cultural backgrounds demand culturally competent programs. Youth-serving organizations are most successful when their programs and services are respectful of the cultural beliefs and practices of the youth they serve.

A culturally competent program values diversity, conducts self-assessment, addresses issues that arise when different cultures interact, acquires and institutionalizes cultural knowledge, and adapts to the cultures of the individuals and communities served.¹ This may mean providing an environment in which youth from diverse cultural and ethnic backgrounds feel comfortable discussing culturally derived health beliefs and sharing their cultural practices.² Creating culturally competent programs is not difficult, but it requires conscientious attention. Here are important steps to take that will help.

- Assess your own values, attitudes, and beliefs about different racial/ethnic groups. Taking stock may help you to address internal biases, recognize personal limits, and identify areas for growth.
- Ask other staff members to take stock as well so that the organization can serve youth in an open, honest, respectful manner.
- Incorporate traditional elements of the culture(s) of youth served. Building upon the cultural beliefs and practices of client youth will reinforce the attitudes and skills the program seeks to strengthen. For example, an HIV prevention program for African American youth might build rites of passage into its efforts.³
- Recognize that youth are individuals, not representatives of their ethnic or racial group. Get to know each individual in the program.³
- Recognize the cultural roots of many behaviors. Youth from different cultures may behave differently, in accordance with what they have learned from their family. For example, some cultures encourage youth to challenge gender roles, whereas others do not. Some encourage an assertive communication style; others encourage a more passive communication style.
- Acknowledge that religious and other beliefs may influence how a young person responds to sexual and reproductive health issues. Some cultures discourage open communication about sexuality, making it difficult for youth to discuss, especially in large groups.
- Recognize that youth from culturally diverse backgrounds may experience varying degrees of acculturation into and comfort with the dominant culture.
- Recognize that some youth are bicultural or multicultural and strongly resist labels that emphasize only one or another of these cultural identities.
- Support young people's exploration of and pride in their individual racial/ethnic identity, including a bicultural or multicultural identity. Ask youth how they self-identify and respect that self-identification.³ This will support youth in building self-esteem and in actively and assertively debunking stereotypes and myths about people of different racial/ethnic backgrounds.
- Develop a "zero tolerance" policy regarding discriminatory words and behaviors based on racial/ethnic or cultural identity, including sexual orientation and gender identity. Post the policy in public areas and develop clear guidelines regarding disciplinary action.
- When training youth or staff to lead workshops, include opportunities for everyone (including volunteers), to practice responding appropriately to unacceptable language and/or behaviors.
- Involve youth as full partners in designing, implementing, and evaluating the programs aimed at youth. Ensure that youth leaders actually represent *all* the cultures served by the program.
- Encourage family involvement. Families offer a positive source of cultural strength as well as a primary source of information and support. Plan activities that encourage family participation.³
- Develop participatory, collaborative partnerships with the community. For example, an advisory committee of community representatives—including youth—can assess the needs of the community.²
- Make every effort to link with existing community service organizations to broaden the array of services available to the community's youth.⁴
- Hire diverse staff reflective of the youth served in the program. Program leaders, guest speakers, and/or volunteers should share the same cultural and ethnic backgrounds as youth.
- Provide language assistance and hire bilingual and bicultural staff.
- Schedule training workshops on cultural competence to provide ongoing education, moving staff from cultural awareness to cultural competence.

- Use diverse materials, including brochures and videos, that are reflective of the cultural and ethnic diversity of the youth and that are culturally, linguistically, and age appropriate. Planners will need to choose these materials wisely. For example, a video that features urban Latino/Hispanic teens may not be appropriate for rural Latino/Hispanic teens.
- Recognize that cultural competence is an ongoing process and make a commitment to building cultural competence in all available ways.

Creating culturally competent programs requires work and determination. The rewards, however, include more effectively 1) reaching young people, 2) achieving positive sexual health outcomes, and 3) supporting youth in attaining their individual goals.

References

- ¹ Goode T, Jones W, Mason J. *A Guide to Planning and Implementing Cultural Competence: Organizational Self-Assessment*. Washington, DC: National Center for Cultural Competence, Georgetown University, Child Development Center, 2002.
- ² Office of Minority Health, U.S. Dept. of Health and Human Services. Revised CLAS standards from the Office of Minority Health. *Closing the Gap*, February/March 2001.
- ³ Messina S. *A Youth Leader's Guide to Building Cultural Competence*. Washington, DC: Advocates for Youth, 1994.
- ⁴ Ross H. Linking minorities to health services: successful strategies for outreach workers. *Closing the Gap*, February/March 2001.

FINDING MY VOICE

By Megan, 17, Online Peer Educator with www.mysistahs.org, Advocates for Youth

After I went through puberty, I lived in considerable fear that I would become pregnant. I feared my body and what it might do. I thought no good could come from being a fertile woman. In high school, I felt weighed down by the pressures of classes, poor body image, and worry about relationships with boys. I could not understand why these concerns had such a great impact on all aspects of my life. Not until high school, when I became interested in women's health, did my personal fears begin to subside.

During my junior year, I decided to learn more about the issues facing young women, especially the issue of teen pregnancy and I realized that I was not the only young woman to feel anxiety about unwanted pregnancy. I attended the National Young Women's Health Summit in Washington, DC, and I was inspired. At the conference, I listened to presentations on teen pregnancy, dating violence and rape, body image, eating disorders, and other topics. I met representatives from organizations like Advocates for Youth and I found the confidence to protect myself and to stand up for all young women of color.

Now, I work with MySistahs, a project of Advocates for Youth. MySistahs is a Web site created by and for young women of color. It focuses on sexual and reproductive health for African American/black, American Indian/Native American, Hispanic/Latina, and Asian American young women ages 13 to 24. Online peer educators provide a fact-based perspective on sexual health as well as informative and confidential, yet friendly and supportive peer-to-peer assistance. In working with MySistahs, I have found my voice.

I recognize that any young woman may face difficult issues, such as deciding whether to have sex and/or what to do to prevent unintended pregnancy and sexually transmitted infections. However, my concern is especially for young women of color. I am American Indian/Asian and I believe that HIV/AIDS is not yet a great threat to my community. However, we face other serious problems, like teen pregnancy and domestic violence. I see MySistahs as an opportunity to educate and empower my peers. I write and listen, hoping to strengthen all of us. Please check out www.mysistahs.org/sistah2sistah.

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BARRIERS TO HEALTH CARE FOR YOUTH OF COLOR

By Tamarah Moss, MSW, MPH, Program Manager, Teen Pregnancy Prevention Initiative

All adolescents, but especially youth of color, need comprehensive and culturally competent sexual and reproductive health care. Unfortunately, adolescents and young adults have less access to health care than any other age group.^{1,2} Teens and young adults, especially those of color, face serious barriers related to sexual and reproductive health care—barriers that may severely limit their ability to avoid pregnancy and STIs, including HIV.³ Committed communities, organizations, and providers can address these barriers and assist youth in overcoming them.

Adolescents Face Service Related Barriers.

Uninsured and underinsured adolescents in the United States are more likely than their insured peers to forego needed health care. Among youth who have health insurance, the current shift from fee-for-service to managed care provides challenges as well as opportunities. Managed care provides more opportunities to monitor and measure the quality of care provided to adolescents and to provide them with preventive services.^{4,5,6,7,8,9} Primary care providers, as gate keepers, can give teens access to specialized care (such as substance abuse or mental health treatment) and the opportunity to identify particular providers with whom youth are comfortable.¹⁰ In meeting the needs of adolescents, managed care can lead to continuity of care and appropriate referral.

On the other hand, adolescents face serious challenges in seeking services from managed care systems. These challenges include limits on services and benefits, a shortage of providers trained in adolescent health, financial and administrative systems that obstruct teens' access to needed services and that sometimes breach teens' confidentiality, and services that focus on adults or children, overlooking the particular needs of teens. Other service related barriers may include waiting rooms where adolescents feel uncomfortable or unwelcome, appointment times that conflict with school schedules, and clinic policies that prohibit walk-in appointments. These barriers contribute to the problems of youth of color, who experience greater difficulty than their white peers in getting early treatment for acute and chronic illnesses as well as appropriate preventive care.^{11,12,13}

Adolescents Face Social, Cultural, and Economic Barriers.

For youth of color in the United States, social, cultural, and economic factors form substantial obstacles to sexual and reproductive health services.

Cultural Barriers—

- **Acculturation**—For youth of color who are first and second generation Americans, acculturation—the degree to which they assimilate the values, beliefs, and behaviors of the host culture¹⁴—is a major factor in health care decisions and use of preventive services. These young people may face language barriers and fear meeting with cultural insensitivity. When youth and providers speak different languages, or rely on a different idiom for the same language, misunderstandings occur, and youth can be made to feel that the misunderstanding is their fault, thus creating a serious emotional barrier to youth's continued use of health care services.¹⁵
- **Communication patterns**—Communication about health and sexuality often differs by ethnicity, age, socioeconomic status, geographic location, and sexual orientation. Communication patterns can form serious obstacles to care. Patterns of speech that presuppose that all youth are heterosexual, share a cultural background, or operate from a single gender role perspective, create instantaneous barriers to care for many young people.
- **Inaccurate assumptions or generalizations**—Any assumption that a single program will meet the needs of all—or even several different—communities of a particular racial/ethnic group in the United States is wildly inaccurate. For example, Native Americans/American Indians possess individual languages, differing customs, and unique cultures and histories. Attitudes toward health and illness, sexuality, and wholeness differ widely. HIV/STI and teen pregnancy prevention programs must be individually tailored to each culture.¹⁶
- **Differing history and community memory**—Because groups within an ethnic community have different histories and differing community memories, a single program will not meet the needs of everyone in the larger community. For example, many African Americans—remembering the infamous Tuskegee syphilis study—are suspicious of government agencies, fearing that genocidal intentions underlay HIV/STI and pregnancy prevention efforts. As a result, they may be unwilling to use condoms and/or to be tested or treated for HIV/AIDS.¹⁶ At the same time, some black Americans, such as those with a Caribbean background, may not share this particular history of governmental abuse. Thus, programs must be tailored to address different cultures.
- **Lack of culturally appropriate materials**—Materials appropriate for one group of clients may simply lack the ability to convey important concepts to another group of clients. For example, many HIV prevention materials that are appropriate for use with some groups of Native Americans/American Indians could be inappropriate for use with Navajo people. Within traditional Navajo culture, speaking about disease is believed to bring it into existence.¹⁷

- **Inadequate language resources**— English-language materials and those translated into a single other language may simply be inadequate. For example, Asian and Pacific Islanders include over 60 ethnic groups, speaking more than 100 languages, and each ethnic and language group needs materials in its own language (and script) as well as culturally appropriate services.¹⁶ At the same time, Latinos may speak English, Spanish, Portuguese, and/or one of many indigenous (Native American) languages. Moreover, the more than 100 different Spanish dialects each have distinctive idioms, usage, and meanings, especially for words related to sexuality. Thus, a program designed by and for first or second generation Puerto Rican youth living in a minority community in an urban, Northeastern region may be totally inappropriate for use with Latinos whose families have lived as landowners in the Southwest for several centuries and whose culture is highly valued in the region.

Economic Barriers—

Poverty, lack of insurance, and/or lack of Medicaid providers are additional barriers to adolescents' use of health care.^{11,18,19} Teens may be unwilling to court humiliation by asking whether services are free or at reduced fees; they may instead fail to seek care.

Social Barriers—

Social barriers may include such factors as the attitudes of peers, family, and religious community as well as mass media influences. For example, peers may relate stories about unpleasant experiences—such as pelvic exams—that deter their friends from seeking health care. Parents and/or religious community may express disapproval of the use of family planning services, thus discouraging teens from seeking services that will help them avoid unwanted pregnancy. Music videos and the film industry present many images of sexualized behavior, but less frequently depict use of preventive health services or of contraception and/or condoms.

Improving Access to Health Care for Youth of Color—Recommendations

Solutions that may be critical in meeting the health care needs of adolescents, especially racial/ethnic minority youth and teens from low-income families, include the following.

1. Provide easy access—via free public transportation, redeemable tokens, or travel vouchers—to comprehensive, coordinated care in convenient locations.¹⁰
2. Ensure that financing mechanisms permit free or low-cost services for adolescents.¹⁰
3. Advertise the availability of free or reduced cost services for adolescents—using flyers, pamphlets, business cards, and posters prominently displayed in the reception area and waiting room(s).
4. Monitor and evaluate services to ensure that teens receive high quality care.^{10 11,18}
5. Establish and monitor mechanisms to ensure teens' confidentiality.^{10 11,18}
6. Publicize confidentiality policies in waiting rooms, advertisements, and handouts.^{16,18}
7. Create a youth-focused waiting room with appropriate décor and music and staff trained to treat youth respectfully and confidentially.¹⁶
8. Set aside special hours for appointments with young people, especially after school, evenings, and Saturdays.¹⁶
9. Leave room in the schedule for walk-in appointments.¹⁶
10. Offer comprehensive, culturally relevant, and age appropriate services (see previous articles in this issue).^{16,18,19}

References

- ¹ Weimick RM et al. *Access to Health Care: Sources and Barriers*. Rockville, MD: Agency for Health Care Policy & Research, 1996.
- ² Klein JD et al. *Adolescents and Access to Care*. New York: New York Academy of Medicine, 1993.
- ³ Melendez Salgado A, Cheetham, N. *The Sexual and Reproductive Health of Youth: A Global Snapshot*. [The Facts] Washington, DC: Advocates for Youth, 2003.
- ⁴ National Committee for Quality Assurance. *Health Plan Employer Data and Information Set 2.0/2.5*/ Washington, DC: The Committee, 1993.
- ⁵ National Committee for Quality Assurance. *Book I HEDIS 3.0*. Washington, DC: The Committee, 1997.
- ⁶ National Committee for Quality Assurance. *Book II HEDIS 3.0*. Washington, DC: The Committee, 1997.
- ⁷ _____. Are HMOs the answer? *Consumer Reports* August 1992:519-530.
- ⁸ Hiramatsu S. Member satisfaction in a staff-model health maintenance organization. *American Journal of Hospital Pharmacy* 1990;47:2270-2273.
- ⁹ Sobczak C et al. Quality measurement and management in an HMO setting. *Topics in Health Care Financing* 1991;18:67-74.
- ¹⁰ English A et al. Meeting the health care needs of adolescents in managed care. *Journal of Adolescent Health* 1998; 22:278-292.
- ¹¹ US Congress, Office of Technology Assessment. *Adolescent Health*, Vols. I & II. Washington, DC: USGPO, 1991.
- ¹² Newacheck PW. Access to ambulatory care for poor persons. *Health Services Research* 1988;23:401-419.
- ¹³ Newacheck PW. Characteristics of children with high and low usage of physician services. *Medical Care* 1992;30:30-42.
- ¹⁴ Dana RH. Assessment of acculturation for Hispanic populations. *Hispanic Journal Behavioral Sciences* 1996;18:317-28.
- ¹⁵ Penn NE et al. Panel VI: ethnic minorities, health care systems, and behavior. *Health Psychology* 1996;14:641-6.
- ¹⁶ Gipson LM, Frazier A. *Young Women of Color and Their Risk for HIV/STD Infection*. [Issues at a Glance] Advocates for Youth. Washington, DC: 1998
- ¹⁷ Carese JA, Rhodes LA. Western bioethics on the Navajo reservation: benefit or harm? *JAMA* 1995;274:826-829.
- ¹⁸ Council on Scientific Affairs, AMA. Confidential health services for adolescents. *JAMA* 1993;269:1420-4.
- ¹⁹ Klein J et al. Access to health care for adolescents: a position paper for the Society for Adolescent Medicine. *Journal of Adolescent Health* 1992;13(2):162-70.

ASIAN AND PACIFIC ISLANDER YOUTH: DIVERSE VOICES, COMMON CHALLENGES

By Man Chui Leung, Program Coordinator, Asian and Pacific Islander Health Forum

Since working with Asian & Pacific Islander (A&PI) youth at local, regional, and national levels for the past six years, I have seen HIV/AIDS issues that are, I believe, unique to A&PI youth. Writing about these issues is difficult, especially since I believe that we have seen only the “tip of the iceberg” regarding HIV/AIDS and A&PI youth.

Why just the tip of the iceberg? To fully understand how HIV/AIDS impacts any community, we need accurate data; yet, it is difficult to assess the true impact of HIV/AIDS on A&PIs because:

1. Data is seldom collected specifically on A&PI people, who are usually relegated to the “other” category, making it impossible to analyze the situation of these communities.
2. When collected, data for different A&PI ethnic groups are usually pooled into one monolithic A&PI category, thereby losing the opportunity to assess HIV/AIDS in each one of more than 60 separate ethnic groups that comprise the larger A&PI community.
3. A&PI people may be undercounted because they are often misclassified in medical records, which usually reflect the opinion of the provider, rather than the self-identification of the patient.
4. Currently, little research targets the larger A&PI community, and even less research focuses on specific A&PI communities or on specific groups such as A&PI youth.

Thus, policy makers, funding sources, and health care providers seldom think about the A&PI community when hearing about HIV/AIDS. A&PIs are all but invisible to AIDS policy makers, community planning groups, epidemiologists, and those who plan culturally or linguistically competent service delivery. HIV/AIDS is invisible to A&PIs, as well, because society’s neglect reinforces a community-wide myth that A&PIs are not vulnerable to the epidemic. Changing both the community’s norms and beliefs and the attitudes and assumptions of policy makers, funding sources, advocates, and service providers is a big challenge for A&PIs.

Despite data limitations, we know that HIV/AIDS cases continue to rise in Asia, the Pacific, and among A&PIs in the United States. We know that one out of five (19 percent) A&PIs living with HIV/AIDS is under age 25 and that female A&PI youth are affected disproportionately by the HIV epidemic. Four percent of A&PI men living with HIV and 14 percent living with AIDS are under age 25 compared to 10 percent of A&PI women living with HIV and 31 percent of A&PI women living with AIDS.¹

The A&PI community is diverse in ethnicity, immigration experience, acculturation, and geography. No common language, culture, or experience unifies this community. Therefore, planners must tailor HIV/AIDS strategies to the unique culture and language of each individual community as well as build connections between different A&PI ethnic groups. Importantly, many A&PI youth are responding proactively—raising HIV/AIDS awareness, tackling sensitive issues such as homophobia, sexism and family pressures, and becoming community leaders.

Local, regional, and national HIV/AIDS programs targeting A&PI youth integrate cultural and language programs and peer education to engage youth and encourage behavioral and social change. For example:

- In Oakland, California, Asian Health Services incorporates hip-hop into a three-session workshop. First, youth identify the hip-hop skill they would like to learn. In the second and third sessions, an HIV expert from the hip-hop community teaches the chosen skill along with important, culturally appropriate HIV/AIDS information.²
- In Los Angeles, California, the Asian Youth Center, Asian Health Care Venture, and Chinatown Service Center incorporate teen theater into prevention efforts. Young people write and produce skits focusing on topics such as HIV/AIDS, teen pregnancy, drug use, peer pressure, and HIV/STI testing and screening. They perform these skits for other youth, families, and schools.³
- In New York, New York, the Asian & Pacific Islander Coalition on HIV/AIDS sponsors bilingual and bicultural young peer advocates who conduct outreach, workshops, and counseling in different languages. The peer advocates reach immigrant youth and help bridge communication gaps between young people and their parents.⁴

Promoting leadership among A&PI youth is crucial to sustaining strategies to meet the changing needs of their communities. In 2001, a national network of A&PI youth, providers, and advocates formed to gather resources, develop leadership among youth, and address critical issues facing these youth. A steering committee—composed of youth from as far apart as Boston and Guam—was chosen to lead the National Asian & Pacific Islander Youth and HIV/AIDS Network. In early 2003, the Steering Committee convened an A&PI Youth Leadership Development Summit that brought A&PI youth together from across the United States and Pacific island jurisdictions to discuss effective local strategies, learn about different leadership styles, and decide how best to advocate and sustain leadership. Through panel discussions and workshops the Summit worked towards the goal of expanding A&PI youth’s skills to become a voice that will not be marginalized or ignored.

A&PI youth face the challenges of tomorrow with proactive, diverse, creative, community-centered, and youth-led strategies. A&PI youth leaders are working to raise awareness so that the larger A&PI community, policy makers, and program planners will realize that HIV/AIDS among A&PI youth is an issue that **must** be addressed.

References

- ¹ Centers for Disease Control & Prevention. *HIV/AIDS Surveillance Summaries* 2002; 13(2):1-44.
 - ² Asian Health Services. <http://www.ahschc.org/> Oakland, CA: Author, 2002.
 - ³ Chinatown Service Center. <http://www.cscla.org/youth.htm>. Los Angeles, CA: Author.
 - ⁴ Asian and Pacific Islander Coalition on HIV/AIDS. <http://www.apicha.org/apicha/main.html>. New York, NY: APICHA.
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OPENING MY EYES AND QUESTIONING THE AMERICAN DREAM

By Shajine, member, Young Women of Color Leadership Council, Advocates for Youth

As an immigrant hailing from Jamaica, West Indies, I have always seen the United States as a country filled with opportunities for everyone to succeed and prosper. As a child, my mother always told me that I could be whatever I wanted to be, and America would give me the chance to achieve all of my goals. My mother's words pressed deeply into my mind and came to influence every decision I made. There was not a strand of doubt in my mind that all doors were open for me to walk through. It was in high school that I began to question the truth behind this perceived "land of opportunity."

As a teenager, my eyes were opened to the world that I lived in. No longer did I see the American dream; instead, I saw Avenue K in Brooklyn, New York. I began to recognize that the concept of the "melting pot" was anything but real. In its place, I noted that every race and class had its own section of the city and this segregation was acceptable. In high school, opportunities seemed divided and limited. The result of a lack of support systems for youth were present all around me as my childhood friends dropped out of school and became pregnant.

Reality hit me incredibly hard. I could not believe kids that I grew up with now had children of their own. It seemed like my peers and I were stuck in a dead-end situation and had no way of getting out. I wondered how I ended up so differently from those around me, and I realized that the support that I had received from my mother had an enormous impact on the person I would become. Her lessons of self-respect and self-confidence taught me how to make thoughtful and responsible decisions for my future and myself. This ability was something my friends had lacked.

In an effort to convey my mother's teachings to others who may be facing similar obstacles, I began working with programs that help youth from low socio-economic backgrounds to attend college. My involvement in the Young Women of Color Leadership Council allows me to work with seven sensational women and allows me the opportunity to share experiences and participate in dialogue about issues concerning youth today. In an effort to continue the great work done by the Leadership Council, I am trying to establish Young Women of Color as an official student organization at George Washington University. I also mentor high school students through Upward Bound and Mentors Incorporated. My involvement with these organizations is a reflection of my commitment that others will be empowered to make responsible, positive choices about their lives and their future.

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MASCULINITY—CONTRIBUTING TO HEALTH DISPARITIES FOR YOUNG MEN OF COLOR

By Maceo Thomas, MPH, Health Educator; Mark A. Boss, PERCY Project Director; and Esther Kaggwa, MSW, Director, National Programs, National Organization of Concerned Black Men

Although human reproduction involves women and men, efforts to improve sexual and reproductive health typically target women only. Moreover, when men are targeted, programs are generally intended, ultimately, to improve the health of young women. Promoting the sexual and reproductive health of young men is essential to enhancing *young men's* overall health, reducing some of the major health risks *they* experience, and encouraging behaviors to prevent unintended parenthood and sexually transmitted infections (STIs), including HIV, in *young men*.¹

Why Intervene in Men's Health?

Males' health is important because young men matter and because a gender gap exists in health outcomes. In 1920, men and women in the United States had an equal life expectancy,² suggesting that there is no inherent, biological life span difference between men and women. Yet today, as in the past eighty years, men in the United States die sooner than women. Today, men's life expectancy is almost six years less than women's.³ Moreover, men have a higher mortality rate than women for all 15 leading causes of death,⁴ and the disparity is even greater for black men. In the last two decades, suicide rates have increased most rapidly among young black men.⁵ Half of all new HIV infections in men occur among black men.⁶ In 2001, the chlamydia rate among African American males ages 15 to 19 was 12 times higher than that among white males (1,550 and 128 per 100,000, respectively).⁷ Recent data document rising rates of syphilis, gonorrhea, and chlamydia among young men who have sex with men.⁸ These differences are not biological, but more than likely behavioral and reinforced by societal definitions of how men should behave.

The Definition of "Masculinity" Contributes to Health Disparities

The health disparities that affect men may be addressed, in part, by examining and changing attitudes and behavior that cultures define as "manly." In fact, males' sexual health cannot be discussed adequately without exploring concepts of masculinity. Merriam-Webster defines masculinity as "having qualities appropriate to or usually associated with a man." Because cultures differ, definitions of masculinity, or what it means to be a man, will also differ. In every culture, "being a man" comprises both positive and negative attributes. Often, being a man means providing for the family. "He always sees that there is a roof over our heads and food on the table." When discussing what it means to be a man, people rarely use adjectives related to sensitivity. For example, one more frequently hears, "He is solid as a rock" than "He is so caring." Programs designed for boys and young men need to reinforce and support the *whole* male. Programs must address masculinity, because societal views of masculinity may be directly related to health disparities affecting men, especially men of color.^{9,10,11,12,13,14}

Men of Color Face Additional Challenges That Contribute to Health Disparities

When definitions of manhood include provider and protector, it is important to recognize that some men of color face challenges in meeting these roles due to such barriers as racism, poverty, lack of education, underemployment, and reduced access to services. These barriers may lead men to adopt survival coping strategies that threaten their health. For example, some young black males adopt the "cool pose" as a coping strategy.¹⁵ The cool pose comprises attitudes and behaviors that present a young man as "calm, emotionless, fearless, aloof, and tough." Young men intend this facade to deliver a message of control in the face of adversity and seemingly insurmountable obstacles. The cool pose suggests competence, high self-esteem, control, and inner strength and hides self-doubt, insecurity, and inner turmoil. This pose often manifests itself, as well, in reluctance to show weakness or to communicate emotions, especially the softer emotions. Such a pose may also encourage "tough" behaviors, such as failure to visit doctors and make it difficult to express warmth and caring in intimate relationships or to negotiate peaceful resolution of conflicts. Tough behaviors, encouraged by the cool pose, certainly contribute toward young men's rates of violence, suicide, substance abuse, HIV infection, and unplanned fatherhood.

The PERCY Project Addresses Sexual Health among Young Black Males

In order to reduce health disparities affecting men, especially young men of color, providers must challenge youth's definition of masculinity. Theory-based programs should utilize interactive, participatory, health communication in culturally appropriate interventions for young men of color. In addition, health programs for males should reflect a male-preferred format including gender-specific and developmentally appropriate materials. The Peer Education and Reproductive Counseling for Young Men (PERCY) Project, developed and implemented by the National Organization of Concerned Black Men, Inc., is a model of such a program. The PERCY Project incorporates innovative programming that works to reduce teen pregnancy and STI rates by challenging the views of adolescent and young adult black males on what it means to be a responsible male.

The PERCY Project is based on the Strain theory, which proposes that inconsistencies between societal expectations and available opportunities for success cause personal frustration and alienation, driving people to risky behavior.¹⁶ To counter frustration and alienation, interventions need to offer skills and strategies to maximize opportunities for the target population. The Project attempts to counter the negative influences of the “cool pose.” Its all male sessions emphasize open communication and the importance of acknowledging personal feelings. Sessions focus on self-esteem, healthy relationships, abstinence, and negotiating the use of protection as well as other subjects that young men seldom discuss. For example, a session may begin with the question “What does it mean to be a man?” followed by, “How does society’s view of being a man influence your sexual behavior?”

Young men of color need culturally specific programs that:

- Provide gender-specific sexual and reproductive information within a cultural context
- Promote a positive self-concept, including self-esteem, self-efficacy, self-respect, and life skills¹
- Build their skills in communication, negotiation, and refusal¹
- Provide confidential access to clinical care and health services¹
- Build youth-adult partnerships by involving young men in programs’ planning, implementation and evaluation.

Upholding traditional notions of masculinity may be said to be killing men. The attitudes and behaviors that young men of color adopt to cope with their culture’s definition of masculinity may lead to the serious health disparities they experience. To eliminate these disparities, innovative, culturally sensitive, gender-specific interventions must challenge young men’s notions of masculinity. These programs must focus on the health and well-being of these young men, not for the sake of young women, but because young men, in and of themselves, are of great value to society.

References

¹ Sonenstein F. *Young Men’s Sexual and Reproductive Health: Toward a National Strategy*. Urban Institute. Washington, DC. 2000.
² Courtenay W.H. College men’s health: an overview and a call to action. *Journal of American College Health* 1998;46:279-290.
³ Centers for Disease Control and Prevention. *National Vital Statistics Report* 2002;50(6).
⁴ Siegried M, Jadad A.R. The future of men and their health. *British Medical Journal* 2001;323:1013-1014.
⁵ National Center for Injury Prevention and Control. *Suicide Prevention Fact*. Atlanta, GA: CDC, 2003. <http://www.cdc.gov/ncipc/factsheets/suifacts.htm>.
⁶ Centers for Disease Control & Prevention. *HIV/AIDS Update*. Atlanta, GA: CDC, 2003.
⁷ *Division of STD Prevention. Sexually Transmitted Disease Surveillance, 2001*. Atlanta, GA: CDC, 2002.
⁸ Centers for Disease Control & Prevention. *Taking Action to Combat Increases in STDs and HIV Risk among Men Who Have Sex with Men*. Atlanta, GA: CDC, [2001].
⁹ Capraro RL. Why college men drink: alcohol, adventure, and the paradox of masculinity. *Journal of American College Health* 2000;48:307-315.
¹⁰ Courtenay WH, Keeling RP. Men Men, gender and health: toward an interdisciplinary approach. *Journal of American College Health* 2000; 48:243-246.
¹¹ Davies J et al. Identifying male college students’ perceived health needs, barriers to seeking help, and recommendations to help men adopt healthy lifestyles. *Journal of American College Health*, 2000;48:259-276.
¹² Eisler RM, Skidmore JR, Ward CH. Masculine gender-role stress: predictor of anger, anxiety, and health-risk behaviors. *Journal of Personality Assessment* 1988;52:133-141.
¹³ Hong L. Toward a transformed approach to prevention: breaking a link between masculinity and violence. *Journal of American College Health* 2000;48:269-279.
¹⁴ Weisbuch M. How masculine ought I be? Men’s masculinity and aggression. *Sex Roles*, April 1999.
¹⁵ Billson JM, Majors R. *Cool Pose: The Dilemmas of Black Manhood in America*. New York: Simon & Schuster, 1992.
¹⁶ Pleck JH. The gender role strain paradigm: an update. In Levant RF, Pollack WS (Eds.). *A New Psychology of Men*. New York: Basic Books; 1995.

I hope one day the world will be tolerant towards people of different backgrounds and there will be an end to racism, homophobia, sexism, and bigotry of any kind. I don’t believe I can change everyone’s mind. But, if I can reach one person and know that his or her life has benefited from my help, then I won’t wear this badge of activism in vain.

Carlos, peer educator and youth activist state organizer

MEETING THE SPECIAL NEEDS OF GLBTQ YOUTH OF COLOR

By Kayla Jackson, MPA, Program Director, National Network for Youth*

Gay, lesbian, bisexual, transgender and questioning (GLBTQ) youth of color face stigma related to both ethnicity *and* sexual orientation. Some also face bigotry related to their gender identity. Surviving racial/ethnic discrimination requires strong connections to family and ethnic community. However, GLBTQ youth of color seldom receive support regarding sexual orientation or transgender identity. Indeed, many ethnic communities perceive gay, lesbian, or bisexual orientation and/or transgender identity as a rejection of ethnic heritage. Unlike racial/ethnic stereotypes that family and community reframe to support young people's healthy development, many ethnic minority communities strongly reinforce negative cultural perceptions of homosexual orientation.¹ This stigma can put these young people at great risk for substance use, violence, and risky sexual behaviors.

African American and Latino young men who have sex with men (YMSM) are more likely than other YMSM to be infected with HIV.² Young lesbians of color, particularly African Americans and Latinas, are at risk for HIV infection and pregnancy due, in part, to the strong value placed on motherhood and childbearing in their ethnic communities.³ Young GLBTQ American Indians are often at increased risk for substance abuse, mental illness, and HIV infection.⁴ The needs of Asian and Pacific Islander GLBTQ youth are likely to be overlooked due to the 'model minority' stereotype, language barriers, and underreporting of AIDS cases.⁵

Most social science models of homosexual identity development are based on the experiences of white, middle- and upper-middle class lesbians and gays.¹ Yet youth of color seldom self-identify as 'gay' or 'queer,' and this may constitute a barrier to their receiving services set up for gay youth. To effectively meet the needs of GLBTQ youth of color, programs must integrate awareness of racism with an understanding of how culture shapes sexual attitudes, values, and beliefs.

Good programs targeting youth of color already fully integrate the ethnic culture(s) of the target youth into their activities, language, and materials. They already acknowledge and incorporate culturally specific values, attitudes, beliefs, and knowledge about health, sexuality, and relationships. But these programs may not yet acknowledge the presence and needs of GLBTQ youth among those they serve. Programs are most likely to be effective in also meeting the needs of these youth of color when:

- Staff assesses his/her own values and beliefs regarding sexual orientation and gender identity. Taking stock will help staff to address internal biases, recognize personal limits, identify areas for growth, and enable programs to service GLBTQ youth of color in an open, honest, respectful manner.
- Create a safe environment. Make it clear that homophobic sentiments and actions have no place in a program. Develop a "zero tolerance" policy regarding discriminatory words and behaviors directed at GLBTQ youth. Ask GLBTQ youth and adults to share some of their experiences. Create safe opportunities for youth to talk openly about racism, sexism, homophobia, and other forms of oppression.
- Consider the social and cultural factors that influence behavior, and acknowledge culturally specific values, attitudes, and beliefs.⁶ At the same time, acknowledge when culture and sexual orientation cause conflicts for GLBTQ youth.
- Involve GLBTQ youth in all aspects of the program's operation.
- Use language that is inclusive with regard to sexual orientation and gender identity.
- Build skills. Include opportunities within the program for *all* youth to build interpersonal skills, especially in conflict resolution, communication, and negotiation. Offer activities and opportunities that are gender and sexual orientation inclusive.
- Don't make assumptions. Ask young people how they self-identify and use these terms.
- Provide peer-to-peer support to change peer norms, and ensure that peer leaders include young people who identify as GLBTQ. All youth benefit by developing leadership, communication, and other pro-social skills and by seeing role models with whom they can identify.
- Focus on the assets of each youth, regardless of sexual orientation or gender identity, and address the needs of the whole person.

Programs that serve youth of color can also serve GLBTQ youth of color through sensitivity, caring, and acceptance. A supportive environment within effective programs can go along way towards reducing the morbidity suffered by many GLBTQ youth of color.

References

- ¹ Ryan C and Futterman D. Social developmental challenges for lesbian, gay, and bisexual youth *SIECUS Report* 2001; 29(4).
- ² Valleroy LA *et al.* HIV prevalence and associated risks in young men who have sex with men. *JAMA* 2000; 284:198-204.
- ³ Centers for Disease Control & Prevention. *Young People at Risk: HIV/AIDS Among America's Youth*. Atlanta, GA: The Centers, (2000).
- ⁴ Pagliaro S, Gipson M. *Effective HIV/STD and Teen Pregnancy Prevention Programs for Young Women of Color*. Washington, DC: Advocates for Youth, 2000.
- ⁵ Center for AIDS Prevention Studies, University of California at San Francisco. *What are Asian and Pacific Islander HIV Prevention Needs?* San Francisco: The Center, 1998.
- ⁶ Ryan C, Futterman D. *Lesbian and Gay Youth: Care and Counseling*. [Adolescent Medicine State-of-the-Art Review; v. 8, no. 2] Philadelphia: Hanley & Belfus, 1997.

* This article originally appeared in *Transitions*, vol.14, number 4, June 2002, © Advocates for Youth. At the time, Kayla was the Director of HIV/STD Prevention Programs at Advocates for Youth.

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D'ANGELO'S STORY

D'Angelo is a former peer educator with YouthHIV.org

My name is D'Angelo, and I am a 22-year-old gay male. My ethnicity is black and Hispanic, and I was born and raised in Washington, D.C. I am back in Washington now after being away for four years for college, and I am working full-time to save money for graduate school. I plan to study for a master's degree in counseling so that I can be a licensed youth counselor.

After remembering how hard it was for me to come out and to accept my homosexuality, I felt the need to help other young people learn to appreciate and become comfortable with themselves as gay individuals before they experienced some of the same difficulties that I did. Coming out wasn't as bad an experience, but it was still tough, nonetheless.

My great grandmother is from the Dominican Republic. I was raised almost completely within black culture, but there were some Latin influences as well. For instance, Thanksgiving dinner typically consisted of turkey, collard greens, fried chicken, chitterlings, flan, arroz con pollo, and chili con carne, among other dishes. We danced the merengue and the electric slide at family gatherings.

Both black and Hispanic cultures are strong, faithful, and proud—which can be good and bad when coming to terms with being gay. It's good because I learned at an early age to be confident and proud of who I am. I learned that life can bring hard times, but I will survive them and persevere, just like my ancestors did. It's bad, on the other hand, because black and Hispanic loved ones can be too strong-willed, faithful, and proud to accept me for the person that I am. I can remember when I was six-years-old and said to myself, "I'm goin' to Hell, and Mom, Dad, and everyone are gonna hate me because I like boys!"

Growing up, I knew that my family wouldn't disown me for being gay, but I did not know if they'd continue to love and treat me the way that they did before I came out. I tried to deny my sexuality for years, to please the people in my life; however I was failing to please the most important person in my life—me! I love my friends and family dearly, but I couldn't live my life this way any longer. I had to come out!

I am lucky! A number of my friends and family are now aware of my sexuality, and they are coping positively. I've received more curious questions from them than I have biased opinions. I feel like they are finally realizing that I am the same D'Angelo they remember from before learning about my homosexuality. The only difference is that I love differently from how they expected. I'm glad that they understand being gay is the only way that I can live my life and still be comfortable in my own skin.

I like to help other youth of color who are struggling to accept their sexuality and to come out to their family and community. I understand far too well the pressures and hardships that they face. Assisting youth of color is my way of also helping communities that aren't educated about sexual orientation. That needs to change!

Continued from Page 14

Resources

- *GLBTQ Transitions*. Advocates for Youth, 2002. Find it online at: <http://www.advocatesforyouth.org/publications/transitions/transitions1404.pdf>
- *I Think I Might Be Bisexual, Now What Do I Do?* Available online at <http://www.advocatesforyouth.org/publications/teenpamphlets/bisexual.pdf>
- *I Think I Might Be Gay, Now What Do I Do?* Available online at <http://www.advocatesforyouth.org/publications/teenpamphlets/gay.pdf>
- *I Think I Might Be Lesbian, Now What Do I Do?* Available online at <http://www.advocatesforyouth.org/publications/teenpamphlets/lesbian.pdf>
- *Young Women Who Have Sex with Women: Falling Through Cracks for Sexual Health Care* available online at <http://www.advocatesforyouth.org/publications/iag/ywsw.pdf>
- *GLBTQ Youth: At Risk and Underserved [The Facts]*, available online at <http://www.advocatesforyouth.org/publications/factsheet/fsglbt.htm>
- *Young Men Who Have Sex with Men [The Facts]* available online at <http://www.advocatesforyouth.org/publications/factsheet/fsyngmen.htm>
- *Cyber Cafes: Improving Access to Information for Youth in High Risk Situations*, available online at <http://www.advocatesforyouth.org/publications/iag/cybercafe.pdf>
- *Young Men Who Have Sex with Men [Issues at a Glance]*, available online at <http://www.advocatesforyouth.org/publications/iag/ymsm.htm>
- Information and resources: publications available online at <http://www.advocatesforyouth.org/glbqtq.htm>
- Supportive communities and referral available online at <http://www.youthresource.com>.

PARTNER COMMUNICATION

By Jennifer Augustine, MPH, CHES, Program Manager, HIV/STI Prevention Programs;
and Nahnahsha Deas, Program Associate, HIV/STI Prevention Programs, Advocates for Youth

Disproportionate rates of teen pregnancy and sexually transmitted infections, including HIV, among youth of color, make it very important that young people discuss sexual and reproductive health issues, including negotiating risk reduction, with romantic and sexual partners. Talking to a partner about these issues can be difficult, but it's vital to protecting one's sexual and reproductive health. These hints may make talking to a partner easier and more effective or, at least, provide a few hints for starting a conversation.

Tips for youth

- To reach mutual understanding and agreement on sexual health issues, choose a convenient time when you will both be free of distractions.
- Choose a relaxing environment in a neutral location, like a coffee bar or a park, where neither of you will feel pressured.
- Use “I” statements when talking. For example, *I feel that abstinence is right for me at this time.* Or, *I would feel more comfortable if we used a condom.*
- Be assertive! Do not let fear of how your partner might react stop you from talking with him/her.
- Be a good listener. Let your partner know that you hear, understand, and care about what she/he is saying and feeling.
- Be “ask-able”—let your partner know you are open to questions and that you won't jump on him/her or be offended by questions.
- Be patient with your partner, and remain firm in your decision that talking is important.
- Recognize your limits. You can't communicate alone or protect you both alone, and you don't have to know all the answers.
- Understand that success in talking does not mean one person getting the other person to do something. It means that you both have said what you think and feel respectfully and honestly and that you have both listened respectfully to the other.
- Get information to help you each make informed decisions.
- Avoid making assumptions. Ask open-ended questions to discuss relationship expectations, past and present sexual relationships, contraceptive use, and testing for STIs, including HIV, among other issues. For example, *What do you think about our agreeing to avoid sex until after we graduate?* Or, *What do you think about our using hormonal contraception as well as condoms?* Not, *Did you get the condoms?* Or, *When will you have sex with me?*
- Ask for more information when unsure. Ask questions to clarify what you believe you heard. For example, *I think you said that you want us to use both condoms and birth control pills? Is that right?* Or, *I think you want us both to wait until we graduate to have sex? Is that right?*
- Avoid judging, labeling, blaming, threatening or bribing your partner. Don't let your partner judge, label, blame, threaten, or bribe you.
- Do not wait until you become sexually intimate to discuss safer sex with your partner. In the heat of the moment, you and your partner may be unable to talk effectively.
- Stick by your decision. Don't be swayed by lines like, *If you loved me, you would have sex with me.* Or, *If you loved me, you would trust me and not use a condom.*

Tips for youth-serving professionals

- Assess your own values, attitudes, and beliefs regarding adolescent sexual behavior and risk reduction.
- Be “ask-able.”
- Avoid preaching or lecturing.
- Provide youth with accurate information and resources on partner communication.
- Give youth opportunities to practice skills such as assertiveness, negotiation, and refusal.
- Learn about the latest sexual and reproductive health information and resources.
- Keep learning about adolescents and the issues they face.
- Attend workshops to build your capacity to address sexual health and partner communication issues with young people.
- Let the young person know if you feel uncomfortable discussing sexuality related issues, but don't let discomfort stop you from listening and responding accurately. If necessary, refer her/him to someone else who can discuss the teen's issues.

LESSON PLAN – NEGOTIATING SEXUAL RISK REDUCTION*

Purpose: To practice communicating comfortably and effectively about sexual risk reduction

Materials: Index cards

Time: 60 minutes

Planning Notes: Have one index card for each participant. Write “**abstinence**” on one third of the cards, “**condom**” on another third and “**condom and another form of contraception**” on the remaining third. Make packets of the cards, containing one of each of the words or phrases to distribute in Step 2.

Procedure:

1. Explain that while *knowing* about the risks of unprotected sexual intercourse is important, the essential thing is to be able to *act* to avoid those risks when with a sexual partner. Explain that this activity will help youth to practice communicating with their partner, the first step in negotiating sexual risk reduction.
2. Divide participants into groups of three and distribute the packets of index cards. Ask each participant to take one index card. Then, go over the following instructions:
 - Create three role-play presentations, one for each situation on your index cards. In each role-play, one person will bring up the subject of sexual risks with another group member and say that she/he wants to use the method listed on the card. The goal of this role-play is for one actor to convince the other actor to agree to practice the assigned method of risk reduction. Tell the youth that the role-plays must end with positive and realistic behavior.
 - While two group members act as characters, the third member should act as a “coach.” The coach will make suggestions to help the actors play their roles and will comment on whether the approach is convincing. Ask all participants to take a turn being the coach.
 - When each small group has finished three role-plays, members of that group will pick the most convincing presentation to perform for the entire group.
3. Tell youth they have 30 minutes to work together and create and practice three role-play presentations. Visit with each group and discuss their ideas for the role-plays. If necessary, make suggestions to get the group started.
4. After 30 minutes, ask a group to volunteer to present first. After the presentation, lead the entire group in a round of applause and ask the audience to provide feedback, using these questions:
 - How realistic was this role-play? Why?
 - Which character was more convincing? Why?
 - What other approach do you think might have been effective?
5. Continue in the same manner with one role-play from each small group. Challenge the teens to redo any role-play they feel they could make stronger after they receive feedback on it.
6. When every group has had an opportunity to present, conclude the activity using the Discussion Points below.

Discussion Points:

1. How did it feel to try and convince someone else to go along with your (assigned) method of risk reduction? How did it feel to have someone else try to convince you? Do you think these feelings are common for youth dealing with these issues?
2. What are effective ways for a couple to discuss abstinence? The use of condoms? The use of condoms and another method of contraception?
3. What should a person do if his/her partner will not agree to a chosen method of risk reduction?
4. What skills or information do you need in order to protect yourself against unintended pregnancies and STIs, including HIV?

* Adapted from *Life Planning Education*; Washington, DC: Advocates for Youth, ©1995.

LIVING WITH HIV

By Christian Fuentes, Youth Advocate, University of California, San Diego, Mother, Child, and Adolescent HIV Program

I did not know what to think when I first learned—at age 13—that I was HIV-positive. I felt overwhelmed to be dealing with a disease that was considered a death sentence. For a long time, I would not discuss HIV with anyone except my doctor or nurse. Six years later in 2001, I started talking about my situation with some of my friends and family, and I felt that I needed to help other HIV-positive youth.

Now I work as a youth advocate at the Mother, Child, and Adolescent HIV Program at the University of California at San Diego, participating in health fairs, distributing information about HIV/AIDS, and presenting on HIV awareness, education, and prevention. I am the executive producer and moderator of a video in which seven HIV-positive youth share their stories. I also assist the HIV Youth Council in San Diego and the Youth-4-Hope program of AIDS Alliance to plan conferences and to involve youth in creating youth-focused HIV prevention services.

HIV-Positive Youth Face Serious Barriers to Care

It takes me by surprise that most people don't realize that youth face many of the same issues that adults face: money, housing, food, language barriers, immigration status, transportation, social stigma, isolation, stress, culture, gang involvement, drugs, alcohol, pressure from peers, negative relationships, pregnancy, violence, depression, discrimination, and ignorance. These barriers also affect youth's priorities. When a teen is worried about finding housing, getting his/her next meal, or being deported, HIV may not be a pressing concern. Moreover, if she/he doesn't know about services in the community or that testing and treatment are important, the teen may not try to get needed services. Finally, if youth fear disclosing their HIV status and cannot express their feelings about being positive, they may avoid the treatment services that will keep them healthy.

What Youth-Serving Professionals Can Do to Meet the Needs of HIV-Positive Youth

- Provide confidential, free or low-cost, youth-friendly services.
- Employ, train, and promote youth as well as adult staff.
- Ensure that all materials are available to match the language(s) and reading level(s) of the youth you serve.
- Engage youth in decorating the clinic or center.
- Ensure that each staff person is knowledgeable about HIV and about serving HIV-positive youth.
- Connect with HIV/AIDS service providers, social services, publicly funded clinics, and youth-serving agencies in the community so that you can refer youth for other needed services.
- Know the laws—federal, state, and local—that pertain to HIV status and to youth.

When I was diagnosed with HIV, I didn't know about support services for youth like me. I didn't know other positive youth who could help me understand how HIV would affect my life. Professionals need to educate HIV-positive youth about being positive and living a healthy lifestyle.

We are the S.A.V.E. Boys Group, a support group of HIV positive young men. S.A.V.E. stands for Strength And Victory Everyday. We were all perinatally infected—we were born with HIV.

BJ: *When I found out that I had AIDS, I was mad. I was scared at first. I didn't like taking my medicine so I threw them away and that's not a good thing for anybody to do. My mom told me if I didn't take all of my medicine I would get sick. I got sick and started taking my meds again. Now I take them all the time.*

Lil' man: *I felt mad, depressed, a lot of things, because I had the virus.*

Tee: *Mom told me...I was ten years old. I didn't know what to think. I was tired and, I just went to sleep. In the morning I realized what she said, so I asked her who knew, and she said, grandma, my aunt, uncle, godmother, and my family.*

Ace: *I was nine or ten. My mom told me. I thought it was real real bad. I forgot what she said. I just know she told me; I heard about HIV, knew it was a disease but didn't know exactly what it was. I didn't have anything to say at the time. My grandma started talking to me more and I started to understand. I was devastated...not now...I just handle it the best I can. I forget about it all the time, until I take my medicine.*

Blaze: *When my friends came to see me in the hospital last month, they were making fun of a girl on my floor, saying she had AIDS. They didn't know that's why I was there, that I had AIDS. It made me feel really bad.*

Jordan: *I'm going to adopt a kid.*

Tee: *I'm going to adopt because I don't want my kid to have the same thing I have - HIV.*

LATINO ADOLESCENTS AND HIV/AIDS

By Romàn Cruz, Director of Community Action, National Latino Children's Institute,
and Carolina Godínez, Senior Program Coordinator, Institute for Hispanic Health, NCLR

Latino Youth Are at Risk.

- The Latino population is the youngest and fastest growing ethnic minority group in the United States. The U.S. Census Bureau estimates that nearly 39 million Latinos live in the United States.¹
- Many Latino youth are sexually active. According to 2001 data from the CDC's Youth Risk Behavior Surveillance System (YRBSS), 46 percent of all U.S. high school students have had sexual intercourse, compared to 48 percent of Latino youth.²
- Among sexually active students in 2001, 58 percent reported using a condom at most recent sex. Latino students (54 percent) were less likely than white or black students (57 and 67 percent, respectively) to report using a condom.²
- HIV/AIDS has disproportionately affected Latinos. Although, Latinos represent 13 percent of the U.S. population, they account for 20 percent of persons living with AIDS as well as 19 percent of cases first reported in 2001.³

Studies consistently show that Latinos receive less preventive care than non-Latinos.^{4,5} Moreover, preventive care may not be an immediate priority for individuals worrying about how to meet the basic survival needs of their families, and Latinos have less access to health education, health care, or culturally and linguistically competent health care providers than do whites or African Americans.^{4,5} Thus, it is imperative to find ways to reach Latino youth with information and services to promote responsible sexual decisions.

Two projects addressing HIV prevention among Latino youth provide examples of key strategies. They are *Charlas Entre Nosotros* from the National Council of La Raza (NCLR), and *Onda Sana* from the National Latino Children's Institute (NLCI). These projects use different approaches and have been implemented in different geographical areas.

Charlas Entre Nosotros

Charlas Entre Nosotros (CEN), a peer-to-peer HIV/STI prevention program implemented by NCLR, is a five-year pilot project involving charter schools and community-based organizations in developing and providing peer-to-peer HIV/STI prevention for Latino youth, ages 13 to 19. CEN's goal is to reduce the incidence of HIV/STIs among Latino youth through education, using effective and culturally appropriate prevention strategies, and reinforcing responsible sexual behavior. CEN works to strengthen 1) youth's ability to resist peer/societal pressures and 2) young people's self-concept, cultural values, and sexual health beliefs. Currently CEN is in its fifth and final year.

Through *Charlas Entre Nosotros*, four community-based organizations were selected to partner with NCLR. Hispanic Health Council in Hartford, Connecticut, offers a comprehensive, community-based approach to serving the Latino community on issues such as maternal and child health, family health promotion, and youth development. Centro Hispano de Hawaii in Honolulu, Hawaii, focuses on community advocacy, arts, and culture. As part of its arts and culture programming, Centro Hispano de Hawaii operates a radio program to reach out to youth, including Asian and Pacific Islander youth. NCLR also partners with a charter school, Calli Ollin Academy in Tucson, Arizona, and with a community clinic, Salud Para La Gente in Watsonville, California, that provides health education and services. Most CEN partners link with local schools, and many youth receive school credit for their CEN community service hours. At every site, youth participate in a *Charla*, consisting of four consecutive sessions involving 15 to 20 youth. The four, two-hour sessions are led by youth facilitators who are trained to lead on basic concepts regarding HIV/AIDS and STI prevention, using an adapted version of *Be Proud! Be Responsible!* *Charlas* are formed with two different age groups: 13- to 15-year-old youth and 16- to 19-year-olds.

Youth and youth leaders have provided evaluation data, indicating that they have enjoyed being part of CEN, being leaders, and having the chance to do something of value for their community. To better meet the needs of Latino youth participating in *Charlas*, NCLR has updated the curriculum to include a module on values, while a module on sexual orientation and gender identity is currently under development.

Onda Sana

Onda Sana uses cultural values and novel strategies to help young Latinos ages nine to 15 to create *una onda sana*—a “healthy wave”—in their community. *Onda Sana* builds on culture and tradition to emphasize the importance of young people's making healthy choices and creating a cadre of like-minded peers. The goal of the program is to reduce behaviors that put young Latinos at risk for HIV infection and to develop strong community leaders.

Several community-based organizations serving Latinos throughout the United States served as pilot sites for the development of program materials and strategies. The *Onda Sana* materials are flexible and can be used in a variety of settings from schools to clinics. Materials developed by youth—such as stickers, posters, sample Web pages, and a tee shirt—provide visual reminders to young people to choose *una onda sana*. In addition, the program sponsors special events to provide community groups the opportunity to discuss HIV/AIDS issues.

One of the strategies of *Onda Sana* is group discussion. The program creates a safe space for young people, as well as their parents, to discuss topics that are generally taboo in the Latino family, including sex, sexuality, substance abuse, and other behaviors that put youth at risk for HIV infection. Some Latino parents may avoid conversations about sexuality issues, saying *De eso no se habla*. (*We don't talk about those things*.) The parent stance, the look, the pointing finger, the *What will your grandparents think?* and other similar gestures and rhetorical questions are not unusual when Latino parents attempt to communicate with their teens. Most of the time, such conversations end up with raised voices and accusations. *You never listen! Or, You are grounded!*

Helping parents and youth communicate can be difficult; but, with activities like “What were you thinking?” the facilitator helps break the ice among parents and they begin to recognize the similarities between their teens and themselves at that age. The facilitator starts by sharing a story of his/her own youth. Most people have memories of actions that they realize could have hurt others or themselves. After a few such stories, parents start to understand how their children, who may now be engaging in similar behaviors, are not very different from themselves at the same age. This exercise levels the playing field. Parents are able to talk more calmly as they begin to open communication with their child. *Onda Sana* provides these and many other activities to help Latino youth and their parents develop and open communication. The activities are designed with Latino traditions and customs to help Latino youth make healthy and wise choices for life.

References

- ¹ U.S. Census Bureau. *Hispanic Population reaches All-Time High of 38.8 Million, New Census Bureau Estimates Show*. [Press release] Washington, DC: The Bureau, June 18, 2003.
- ² Centers for Disease Control & Prevention. Youth risk behavior surveillance, United States, 2001. *Morbidity & Mortality Weekly Report, Surveillance Summaries* 2002; 51(SS-4):1-64.
- ³ Centers for Disease Control & Prevention. *HIV/AIDS Surveillance Report* 2001;13(2).
- ⁴ Centers for Disease Control & Prevention, National Center for HIV, STD and TB Prevention. *Protecting the Health of Latino Communities*. Atlanta, GA: Author, 2000.
- ⁵ Kates J. *Latinos and HIV/AIDS*. Menlo Park, CA: Kaiser Family Foundation, 2001.

MY HONOR IS TO SERVE

By Chanel, Peer Educator, Advocates for Youth

Growing up in the Brownsville section of Brooklyn, my biggest concerns were avoiding pregnancy, maintaining my “thugged out” persona, and earning money. This mentality led to my involvement in the negative street activity that characterized my neighborhood.

However, my involvement in the City Kids Foundation, a non-profit organization that uses the arts to help engage and develop youth, provided me with options not usually available to a young person from my background. This program taught me about ongoing local and global issues and allowed me to find a role I could play to improve these conditions. In turn, I was able to transform my feelings and experiences into artistic pieces. I was empowered to believe that my world was not dictated by the hustle of the streets. I became confident that my destiny was bigger than my community and my circumstances. I knew that I could achieve anything because I possess a unique and limitless combination of creativity, strength, energy and imagination. Coupled with my passion and personality, I became a vibrant and active force that would make a constructive difference in our world.

With this arsenal of confidence, I ventured on to college. Admiring the incredible work done by CityKids, I sought similar venues and started working closely with the National Organization for Concerned Black Men’s Educated Choices for Healthy Outcomes (ECHO) Project. In my role as a health trainer, I facilitate workshops with middle and high school students on topics around sexual activity. I teach my students about the choices they have in life and challenge them to not always take the easy road.

The past year has been amazing. The connections I have made with my students are reflected in the depth of our sessions, which are full of emotion and self-disclosure. My students know that they can count on me for encouragement and support. Some of them have come to me with extremely personal situations asking for my advice and/or assistance. I feel honored that they have chosen to confide in me some of their deepest feelings and frustrations. I value my experiences with them, not only for what I have been able to teach them, but also for what they have taught me. Knowing that my purpose is to positively impact the lives of others so they may positively empower themselves and their world gives meaning to my existence.

Taking on this responsibility is awesome. I refuse to let my desire to lead, entrepreneurial drive, and commitment to community service go to waste. I plan to use these attributes to establish a community-based organization that will act as a support network to empower young people. I look forward to the day when I will return to the streets of Brooklyn, with these gifts, and share with others the feelings of purpose and worth that were given to me.

INNOVATIVE STRATEGIES—PREVENTION THROUGH THE ARTS

By Jane Norman, Director, Youth Empowerment Initiatives

With the continued high rates of HIV infection amongst youth, especially youth of color, GLBTQ youth of color, and young men of color who have sex with men, some educators and activists are finding new and innovative ways to reach youth with prevention messages.

Theater

Groups such as City at Peace in Washington, DC (www.cityatpeace.org) and The Nitestar Program in New York City use theater productions, written and performed by teens, as a way to reach large numbers of young people with information about HIV/AIDS and other sexual health issues. While it is unrealistic to expect one performance to change audience members' behavior, plays and theater can stress the importance of individual prevention efforts, provide information, debunk myths and stereotypes, model protective attitudes and behaviors, and link members of the audience to prevention, testing, and treatment services. Crucially, theater and other performance interventions can effectively address one of the most difficult issues for prevention educators—the perception of invulnerability, the belief that *HIV isn't something I have to worry about*.

Once audience members have been reached affectively through the drama or humor of the performance and have achieved an empathetic connection with the characters, the individuals in the audience may be open to prevention messages. Then, when performances are followed by question and answer sessions, audience members can ask questions of the performers (who remain in character), perhaps internalizing messages they had heard, but hadn't assimilated before. Sometimes productions are followed by workshops that offer audience members the opportunity to build skills, such as assertiveness.

Radio

Radio soap opera provides another medium for reaching large numbers of people, including those in rural areas or areas with low literacy rates or little access to education. Such projects are used widely in developing countries. The soap operas develop loyal fans, and the realistic situations and characters can provide correct information about a number of sexual health issues as well as model effective communication and negotiation strategies. The Communication Initiative (www.comminit.com) collects case studies on sexual health messaging through soap operas and other mass media.

Film

Scenarios USA takes this concept one step further and produces short films, written by and for young people, designed to promote sexual responsibility and healthy behaviors. Based on successful campaigns conducted by community organizations in France and West Africa, Scenarios USA is an innovative sexual health campaign in which schools, community organizations and media professionals join to support youth in writing, scripting, and producing short films (www.scenariosusa.com).

Music

Music strongly influences youth. The Adolescent AIDS Program at Children's Hospital at Montefiore Medical Center in New York City put hip-hop to work for HIV prevention. Using music, videos, and magazines, *HIV and the Hip-Hop Culture: Choices, Challenges and Care* deconstructs hip-hop music and lyrics as well as the social forces that influence young people's choices with regard to sexual behavior, relationships, culture, and other sexual health issues (www.adolescentaids.org).

The Taskforce of Greater Cleveland, Ohio, uses hip-hop music and videos to provide information about safer sex and making sexual decisions. Young audiences identify with the content, appreciate the creative approach, and are responsive to the prevention messages, and the Taskforce hopes that young people will 'own' and promote the positive messages throughout their social circles (www.aidstaskforce.org).

Poetry

Poetry slams are gaining in popularity across the country. Heavily influenced by jazz, rap, and hip-hop, slam poetry is the competitive art of performance poetry, putting a dual emphasis on writing and performing. Groups such as WritersCorps give young people a creative, nonviolent outlet for their frustrations and conflicts. WritersCorps holds writing workshops in public schools, homeless shelters, and community centers, working to engage young people in exercising their creative energy and to build their self-esteem through writing. Competitive poetry slams, where youth read and perform poetry in 'verbal boxing matches,' allow young people to be a visible, creative force in their community. WritersCorps currently has projects in Washington, DC, San Francisco, and the Bronx. Another group, the New School Activists (a youth-led theater project of MetroTeenAIDS) uses slam poetry, games, break dancing, and music to accomplish HIV prevention with urban flair (www.metroteenaids.org).

Empowerment

The Sister to Sister/Hermana a Hermana program in Washington, DC, is an arts and leadership program to empower girls and young women. As the founder, Marta Urquilla, says, *We consider the arts an effective vehicle for encouraging positive self-*

expression and for strengthening community. Participants rely upon alternative modes of expression—visual arts, poetry, dance, and performance—to communicate who they are and who they want to become. We encourage the arts as a means to explore and overcome personal struggles and confrontations... We define health as a young woman’s foundation, her backbone, emotional, physical, mental, and social—that empowers her to make necessary choices to survive, provide for herself, and take action on her own behalf and that of others (Sts_coordinators@yahoo.com).

Although research has not yet proved that linking art and prevention messages will result in the adoption or maintenance of sexually healthy behaviors, the young people who are the creators and the consumers of these nontraditional interventions attest to art’s power to reach and teach.

NATIONAL RESOURCES

Advocates for Youth

202.419.3420

www.advocatesforyouth.org

AmbienteJoven.org

202.419.3420

www.ambientejoven.org

Asian and Pacific Islander American Health Forum

415.954.9988

www.apiahf.org

MySistahs.org

202.419.3420

www.mysistahs.org

National Council of La Raza

202.785.1670

www.nclr.org

National Latina Health Network

202.965.9633

www.nationallatinahealthnetwork.com

National Minority AIDS Council

202.483.6622

www.nmac.org

National Native American AIDS Prevention Center

510.444.2051

www.nnaapc.org

National Organization of Concerned Black Men

888.395.7816

www.cbmnational.org

National Youth Advocacy Coalition

202.319.7596

www.nyacyouth.org

Office of Minority Health and Resource Center

800.444.6472

www.omhrc.gov

YouthHIV.org

202.419.3420

www.youthHIV.org

YouthResource.com

202.419.3420

www.youthresource.com

When asked why I am a youth activist, I tell people that I am a “youth activist in the making.” I once thought that an activist was someone who was really involved in politics. Now, I know that a youth activist is a one who strives to create positive social change in whatever issue she/he feels compelled to.

Valencia, MySistahs online peer educator & member, Young Women of Color Leadership Council

THE BADGE OF ACTIVISM

By Carlos, Peer Educator and State Organizer

Hello. My name is Carlos. I wrestle for my high school. I am a 16-year-old sophomore and I'm gay. I've always been active in sports. It's tough, being around homophobic people, and not having the opportunity to come out. I don't plan on pursuing a wrestling career, though; I want to become a movie director and work on my activism that way. I like to break down stereotypes.

I'm also Hispanic and very proud of my heritage. I come from a strong Hispanic and military background. My father is a Marine, and my mother, a strong Mexican woman. Both influenced me to take a stand for what I believe in, and both support me in my fight for tolerance and equality for all. I thank them for influencing me in advocacy work.

I remember one night I was looking at different Web sites for groups such as the National Youth Advocacy Coalition (NYAC), the Gay Lesbian and Straight Education Network (GLSEN), and Parents, Friends, and Families of Lesbians and Gays (PFLAG), searching for resources on how to come out. I was also looking for activism in my community, especially for GLBTQ (gay, lesbian, bisexual, transgender, and questioning) youth. Each of these advocacy organizations provided me with some great information about activism. Then, I bumped into YouthResource, a Web site created by and for GLBTQ youth. It was a great Web site and very helpful. It dealt with issues from religion to coming out; I was amazed. While viewing YouthResource, I saw that there were positions open as online peer educators. I wanted to participate so badly, but knew I had to come out to my parents first.

First, I came out to my mom when I moved back in with her. She didn't care. I was still her angel. Then, I came out to my dad and it was tough. My father, a hardcore Marine, was at first very upset. But I let him know that nothing would change and that I am still the same person. Everything is fine now. Nothing has changed, except for us being more honest with each other. The experience showed my dad that I was not weak, that I knew what I was talking about.

Currently, I'm an online peer educator for YouthResource. I've been given the chance to help youth and, through working with them, have gotten involved with Advocates for Youth. Recently, Advocates started an initiative called My Voice Counts, which promotes comprehensive approaches to sex education and opposes public funding for unproven abstinence-only-until-marriage programs. I decided to get involved, and now I'm a state organizer for southern California. My advocacy work has given me great contacts and job opportunities around my area.

Being an advocate is not an easy task. It demands much time and effort to make something happen. I'm not an advocate to make a name for myself, but to fight for what I believe is right: equality and peace—two of the things we most need, but also two of the hardest to obtain.

I hope one day the world will be tolerant towards people of different backgrounds and there will be an end to racism, homophobia, sexism, and bigotry of any kind. I don't believe I can change everyone's mind. But, if I can reach one person and know that his or her life has benefited from my help, then I won't wear this badge of activism in vain.

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Advocates for Youth is a national, nonprofit organization dedicated to creating programs and advocating for policies that help young people make informed and responsible decisions about their reproductive and sexual health.

Like most nonprofits, we rely on contributions from individuals to help sustain our work. If you have found this copy of *Transitions* to be useful and are interested in supporting the work of Advocates for Youth, please consider making a contribution today. Your gift of \$25, \$70, \$100, or more will help give young people the information and tools they need to make informed and responsible decisions. You may also make a contribution or learn more about Advocates by visiting www.advocatesforyouth.org.

YOUTH OF COLOR PROJECTS OF ADVOCATES FOR YOUTH

- Spanish-Language Media Initiative—working with the Spanish-language entertainment industry to encourage the inclusion of sexual health messages into television programming
- AmbienteJoven (www.ambientejoven.org)—by and for Latino/Latina GLBT youth and for young men who have sex with men (YMSM)
- MySistahs (www.mysistahs.org)—by and for young African American/black, Latina/Hispanic, Asian and Pacific Islander, and Native American women ages 13 to 24
- The Young Women of Color Leadership Council—diverse young women of color from across the United States coming together to fight the disproportionate affect of HIV/AIDS on their communities www.advocatesforyouth.org/about/ywoclc.htm
- The Youth of Color Initiative—a partnership of Advocates for Youth and national minority organizations and their affiliates to provide technical assistance and training on HIV/STI and pregnancy prevention for youth of color <http://www.advocatesforyouth.org/about/yoc.htm>.

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